BOARD OF PODIATRIC MEDICINE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: James C. Van Wagenen, D.P.M. License # E-1203 Respondent.	No. D-3744

DECISION

The attached Stipulation of the Board of Podiatric Medicine is hereby adopted by the Department of Consumer Affairs, State of California, as it's Decision in the above-entitled matter.

This Decision shall become effective on December 8, 1988.

IT IS SO ORDERED December 8, 1988.

BOARD OF PODIATRIC MEDICINE
Department of Consumer Affairs
State of California
William Landry, D.P.M., Chairman

ORIGINAL

JOHN K. VAN DE KAMP, Attorney General
of the State of California
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JAMES C. VAN WAGENEN, D.P.M. 3381 North Bond Avenue Fresno, CA 93726 License No. E-1203 Respondent.	No. D-3744 STIPULATION, DECISION AND ORDER

The Board of Podiatric Medicine, through its legal counsel John K. Van de Kamp, Attorney General, by and through Deputy Attorney General Joel S. Primes, and James C. Van Wagenen, D.P.M., by and through his legal counsels, Theodora Poloynis-Engen and Steven A. Brown.

1. On or about August 25, 1965, respondent James C. Van Wagenen, D.P.M. (hereinafter "respondent") was issued license No. E-1203 by the Board of Podiatric Medicine (hereinafter "Board"). Respondent has engaged in the practice of podiatric medicine in the State of California pursuant to the certificate

which remains in good standing.

2. On or about September 6, 1988, the Board filed a First Amended Accusation No. D-3744 against respondent. Said accusation was filed by Carol Sigmann, Executive Officer for the Board, acting in her official capacity.

3. Said accusation, statement to respondent, copies of Government Code sections 11507.5, 11507.6, and 11507.7 and notice of defense were duly served upon respondent. Respondent filed a timely notice of defense.

4. Respondent has retained legal counsel to advise him as to the allegations made in the accusation and in executing the stipulation. Respondent is represented by Theodora Poloynis-Engen and Steven A. Brown.

5. Respondent desires to avoid the expense and emotional distress attendant to a full evidentiary hearing and therefore enters into this agreement.

6. For the purposes of this proceeding and any subsequent proceeding between the parties, respondent admits the allegations listed in the First Amended Accusation. (Attached and incorporated herein as Exhibit A.) Respondent admits that the following allegations constitute repeated negligent acts:

Patient Julia B.

Page 3, paragraph 2;

Page 4, paragraph 3; and

Page 4, "Post-operation management."

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Patient Margaret M.

Page 7, paragraphs 1, 2, 3, 4, 5, 6, and 7.

Patient Annette J.

Page 10, paragraphs 2, 3, and 4.

Patient Wanda K.

Page 12, paragraphs 2, 3, 4, and 5.

Respondent asserts he had a good faith belief that his actions were warranted given the symptoms presented. In the interest of fairness, the following allegations are dismissed:

Patient Julia B.

Page 3, paragraph 1.

Patient Margaret M.

Page 8, paragraph 8.

Patient Annette J.

Page 10, paragraph 1.

Patient Wanda K.

Page 12, paragraph 1.

7. Respondent has discussed the charges and allegations of the violations alleged in accusation No. D-3744 with his legal counsel and is aware of his rights under the Administrative Procedure Act of the State of California, including his right to a formal hearing and opportunity to defend against the charges, the right to reconsideration and the right to appeal any adverse decision that might be rendered following the hearing.

8. Respondent waives the right to a hearing, the right to cross-examine witnesses, the right to present evidence in his

defense, the right to introduce evidence in mitigation, the right to reconsideration, and the right to appeal any adverse decision which the Board might render following an administrative hearing held pursuant to the provisions of the Administrative Procedure Act of the State of California.

9. Respondent has been informed by his legal counsel that as a direct consequence of waiving the aforementioned rights and making the aforementioned admissions and stipulations, the Board may issue an order and decision disciplining his license, No. E-1203.

10. Based on the admissions and waivers set forth in this stipulation, respondent agrees that the Board may issue the following order:

ORDER

Certificate No. E-1203 heretofore issued to respondent is hereby revoked. However, the revocation is stayed and respondent is placed on probation for five years upon the following terms and conditions:

A. Board Fine

1. Respondent shall pay to the Board as a fine $15,421.74 and said amount is due in full within four and one-half years following the effective date of this stipulation. Respondent may make quarterly payments to the Board over a four and one-half year period with the first installment due 120 days following the effective date of this stipulation. Subsequent installments shall be due every 90 days from the date of the first installment. Said payments shall be sent directly to the

Board or its designee.

2. Failure to pay the $15,421.74 fine in regular installments, with no less than one-third having been paid at the end of 18 months of probation following the effective date of the decision; and subsequent thirds at the end of each of the following 12 months and 24 months, will result in revocation of the license without any further hearing until such arrearage has been paid.

3. Failure to pay the total amount of $15,421.74 by the end of five years following the effective date of the decision will result in revocation of license No. E-1203 without further hearing. This fine shall not be discharged in bankruptcy.

B. Education Courses

Within 90 days after the effective date of this decision, respondent shall submit to the Board, or its designee, for approval an educational program of pharmacology, surgical principles, infectious disease and perioperative evaluation. The educational program shall consist of not less than 40 hours per year for the first two years of probation, and 25 hours per year for each subsequent year of probation. The educational program shall be in addition to the Continuing Medical Education (hereinafter "CME") requirements for relicensure. Upon the completion of each course, the Board, or its designee, may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance at the CME courses required by this educational courses requirement to the Board on an annual basis. Respondent shall also provide proof of

attendance at the CME courses required for relicensure at license renewal periods occurring during the probationary period.

C. Compliance with Required Continuing Medical Education

Respondent shall annually submit satisfactory proof to the Board of compliance with the requirement to complete 50 hours of approved continuing medical education for relicensure during each two-year renewal period.

D. Oral Clinical Examination (OCE)

Respondent shall take and pass an oral clinical examination to be administered by the Board, or its designee, subject to the following conditions:

1. The examination shall consist of no more than five questions of a practical, clinical nature. The purposes of this examination, which shall be communicated to the examiners in advance of the examination, are to identify areas of practice needing remediation, if any, and to ascertain whether respondent is able to practice podiatric medicine with reasonable skill and safety to patients. The examination shall not include questions regarding the treatment of ankles.

2. Respondent shall take an OCE within 90 days of the effective date of this decision. If respondent fails the examination, or refuses to take the examination, he shall, without further hearing, cease to perform all podiatric medical and surgical care except for the routine trimming of corns, callouses and toenails and the treatment of superficial skin conditions, physical therapy and whirlpool.

3. The OCE shall be administered in accordance with the "Oral Examination Instructions for Licensure Candidates," except that respondent will not be examined on the ankle. The final ruling on whether respondent passed or failed the OCE shall be subject to the Board's initial split panel review procedure and post examination appeal procedure contained in 16 California Code of Regulations section 1399.661.

4. Respondent shall take a second OCE within 90 days after receiving written notification that he has failed, or refused to take, the first OCE. Upon failure of, or refusal to take, this OCE, a notice shall be issued from the Board ordering respondent to cease the practice of podiatric medicine, and license certificate No. E-1201 is revoked without further hearing until he takes and passes said OCE.

5. Respondent shall pay the costs of each OCE.

6. If respondent demonstrates any areas of deficiencies in the clinical practice of podiatric medicine during the OCE, the areas of deficiencies shall be included in the CME requirement and added to "Educational Courses" set forth in this stipulation.

7. All examinations shall be administered by two examiners selected from a list of 15 names that shall first be submitted to respondent who shall have the right to disqualify up to 8 names therefrom. The Board shall provide to respondent the curriculum vitae for each nominee. This information will accompany the list.

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8. Commencing with the effective date of the Board decision and until respondent passes the OCE respondent shall perform no first and fifth metatarsal osteotomies. All other surgeries require prior approval from his monitor.

E. Monitor

Respondent must have the aspects of his practice involving all podiatric medical and surgical care (except the routine trimming of corns, calluses and toenails and treatment of superficial skin conditions, physical therapy and whirlpool) subject to the review and supervision of another doctor of podiatric medicine who shall act as a monitor on behalf of the Board. Within 30 days from the effective date of the decision, respondent shall nominate at least three doctors of podiatric medicine to serve in the capacity of monitor and shall submit the names of the three nominees to the Board, or its designee, for approval. If the Board rejects all the names submitted, respondent shall have fourteen (14) days from receipt of notice thereof in which to submit another list of at least five names. If the nominees are again rejected the Board or its designee shall allow respondent to nominate 10 more licensees. The selection of a monitor shall be accomplished within 4 months of the Board decision. The parties shall each exercise due diligence and good faith in the selection of a monitor.

1. Respondent shall pay the costs of establishing and maintaining the monitor. The financial relationship between respondent and the monitor shall be recorded in a written contract, attached hereto as attachment B, to be used by

respondent and his monitor. The cost of the monitor shall not cause or involve additional charges to patients.

2. The monitor shall visit the respondent twice a month for the first three months of probation and once a month for the duration of the probationary period.

3. The Board shall have the right to terminate the monitor, if it determines that the monitor has failed to execute the duties, responsibilities and powers vested in him or her by the terms of the stipulation in a professional manner. Respondent shall accept the decision of the Board to discharge the monitor.

4. If the monitor becomes unable to serve for the duration of the probationary period, he or she shall provide a written resignation to the Board, or its designee, within 10 days prior to the date on which he or she ceases to serve as monitor.

5. If the monitor resigns, respondent shall nominate at least three doctors of podiatric medicine to serve in the capacity of monitor and shall submit the names of the three nominees to the Board or its designee for approval within 30 days of the effective date of the resignation of the prior monitor. If the Board rejects all the names submitted, respondent shall have fourteen (14) days from receipt of notice thereof in which to submit another list of at least five names. If the nominees are rejected, the Board, or its designee, shall appoint a monitor within 45 days of the resignation of the prior monitor. Respondent shall accept the selection of the monitor. The parties shall each exercise due diligence and good faith in the

selection of a monitor.

6. If the Board, or its designee, determines that the resignation of the monitor is caused by the failure of respondent to fulfill the terms of the contract with the monitor, or is caused by the interference of respondent with the duties of the monitor, respondent shall be deemed to be in violation of probation and upon written notification by the Board, or its designee, and following said hearing the Board may issue an order to respondent to cease to practice podiatric medicine until the Board, or its designee, appoints a new monitor. Respondent shall accept the selection of the monitor.

7. Respondent shall complete a minimum of 2 years under the review and supervision of the monitor, subject to the terms provided in the stipulation and contract. At the conclusion of the 2-year period, the monitor shall submit to the Board, or its designee, a written recommendation concerning the need for continuing the monitorship. While on probation upon the recommendation of the monitor, the Board may continue to require the monitor, reduce the duties of the monitor, or eliminate the requirement of the monitor.

F. Prior Approval for Podiatric Surgery

While on probation, respondent shall obtain the prior approval of the monitor prior to performing any podiatric surgery. Exception: The routine trimming of corns, callouses and toenails and treatment of superficial skin conditions, physical therapy and whirlpool.

1. When seeking prior approval, respondent shall use

the written forms provided by the Board. (See attachment C.) Respondent shall include on the forms an assessment as to the appropriateness of, and indication for, the procedures to be used, including the review of all preoperative records and laboratory evaluations, a delineation of the contraindications for the procedure, and approval for the surgery.

2. All authorizations shall be signed and dated by the monitor and respondent. All patient care approval forms submitted to the monitor shall be forwarded to the Board, or its designee, by certified mail on a monthly basis by the respondent. Respondent shall maintain evidence of surgery authorizations for each patient. However, such authorizations shall not become a part of the permanent medical records of the patient.

3. Respondent is authorized, if necessary, to mail all patient records to the monitor to obtain approval. For purposes of this stipulation, patient records are all data obtained and utilized by respondent in evaluating and treating surgical patients.

4. The monitor may authorize treatment by telephone after a review of all patient records. The patient records shall be subject to inspection by the Board, or its designee, upon reasonable notice by the Board, or its designee.

5. Respondent shall keep a log of all podiatric and medical surgical procedures performed (except for the routine treatment of corns, callouses and toenails and superficial skin conditions). The treatment log shall include entries for (a) the date of the initial visit, (b) date of informed consent, (c) the

date the treatment/surgery was performed, and (d) the type of treatment/surgery performed.

During the visits of the monitor, the monitor shall randomly select and review the postoperative and other medical treatment records of at least ten percent of the total patient care cases recorded in the logs. The monitor shall evaluate the appropriateness of care and shall provide a monthly written summary of findings to the respondent and to the Board, or its designee. The patient care logs shall be subject to inspection upon reasonable notice by the Board, or its designee.

6. Respondent is prohibited from performing any surgery on the first visit of a patient unless the surgery is required by a medical emergency. Respondent shall keep a written record of all surgeries required by medical emergencies in a separate log book and this log book shall contain the information required of all other surgeries.

G. Patient Charts

Each patient chart shall contain a record of the chief complaint of the patient in the handwriting of the patient or signed by the patient. Each patient chart shall contain a record of all diagnostic tests performed, pertinent information involving conservative therapy decisions, and documentation that respondent has noted the results and the justification for action taken or not taken. Respondent's treatment decision shall be outlined with reference to diagnostic tests.

H. Cessation of Practice Procedure

Respondent shall comply fully with the protocol

established by the Board for suspending, or concluding, the podiatrist-patient relationship if respondent is required, pursuant to the terms and conditions of the stipulation, to cease the practice of podiatric medicine entirely, or to cease performing the surgical procedures requiring the prior approval of the monitor. The protocol shall include, but is not limited to, the time and manner of suspending or concluding the podiatrist-patient relationship, referral of patients to other physicians or podiatrists and continued medical treatment of patients. The Board shall provide the written protocol for suspending or concluding the podiatrist-patient relationship concurrently with its notification requiring respondent to limit or cease his practice of podiatric medicine as required by this stipulation. Respondent shall have 45 days from Board notification to comply with this procedure. The Board shall continue the procedure upon a showing of reasonable cause.

I. Tolling for Cessation of Practice

In the event respondent fails to satisfactorily complete any provision of the order of probation, which results in the cessation of practice, all other provisions of probation other than the submission of quarterly reports shall be held in abeyance until respondent is permitted to resume the practice of podiatry. All provisions of probation shall recommence on the effective date of resumption of practice. Periods of cessation of practice will not apply to the reduction of the probationary period.

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J. Obey All Laws

Respondent shall obey all federal, state and local laws, and all rules governing the practice of podiatric medicine in California.

K. Quarterly Reports

Respondent shall submit quarterly declarations, under penalty of perjury, on forms provided by the Board stating whether there has been compliance with all the conditions of probation.

L. Surveillance Program

Respondent shall comply with the Board's probation surveillance program.

M. Interview with Podiatric Medical Consultant

Respondent shall appear in person for interviews with the Board's medical consultant, upon request, at various intervals, and with reasonable notice.

N. Tolling for Out-of-State Practice or Residence

In the event respondent should leave California to reside or to practice outside the state, respondent must notify the Board in writing of the dates of departure and return. Periods of residency or practice outside California will not apply to the reduction of this probationary period.

O. Completion of Probation

Upon successful completion of probation, respondent's certificate will be fully restored.

P. Violation of Probation

If respondent violates any of the terms and conditions

of probation in any respect, the Board, after giving respondent notice and an opportunity to be heard,may revoke probation and carry out the disciplinary order that was stayed.

If an accusation or petition to revoke probation is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final and the period of probation shall be extended until the matter is final. There are no other investigations pending against respondent at this time.

Q. This stipulation is unique to this case. It is not a precedent and should not be considered as an example of a model stipulation.

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There are no other investigations pending against this respondent at this time.

R. The parties agree that this document shall be null and void and not binding upon the parties unless and until it is approved by the Board of Podiatric Medicine.

10/14/88
Date

Joel S. Primes
Deputy Attorney General
Counsel for Complainant

10/5/88
Date

Steven A. Brown, Esquire
Counsel for Respondent

10/10/88
Date

Theodora Poloyris-Engen, Esquire
Counsel for Respondent

I have read the foregoing stipulation and proposed decision and order. I understand I have the right to a hearing on the charges made in accusation No. D-3691, the right to cross-examine witnesses, and the right to introduce evidence in mitigation. I knowingly and intelligently waive these rights and agree to be bound by the terms of the stipulation, decision and order.

10-6-1988
Date

James C. Van Wagenen, D.P.M.
Respondent

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EXHIBIT A

JOHN K. VAN DE KAMP, Attorney General
of the State of California
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Attorneys for Complainant

BEFORE THE BOARD OF PODIATRIC MEDICINE
BOARD OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JAMES C. VAN WAGENEN, D.P.M. 3381 North Bond Avenue Fresno, CA 93726 License No. E-1203 Respondent.	No. D-3744 FIRST AMENDED ACCUSATION

Complainant Carol Sigmann, for a first amended accusation, alleges:

1. Complainant is the Executive Officer of the Board of Podiatric Medicine, Board of Medical Quality Assurance and makes and files this first amended accusation in such official capacity. This First Amended Accusation supersedes and replaces nunc pro tunc the accusation heretofore filed.

2. On August 25, 1965, respondent was issued California podiatrist license number E-1203. Respondent's license is current with an expiration date of March 31, 1988.

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3. The Board of Podiatric Medicine has jurisdiction over this matter pursuant to Business and Professions Code section 2497.[1/]

4. Respondent is subject to disciplinary action pursuant to Business and Professions Code section 2234(b)[2/] in that respondent is guilty of gross negligence as is more specifically set forth herein.

5. Respondent is subject to disciplinary action pursuant to Business and Professions Code section 2234(d)[3/] in that respondent is guilty of incompetence as is more specifically set forth herein.

A. Patient: Julia B., Age: 50

The patient first presented on August 13, 1984 with complaint of pain in both bunion joints, the right more than the left. Respondent notes "no pain on palpation of the right." On October 16, 1984 respondent performed metatarsal osteotomies in the middle to distal one-third of the shafts of the first and fifth metatarsal of both feet. Respondent did not use any form

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1. Business and Professions Code section 2497 provides: "The board may order the denial of an application for, or the suspension of, or the revocation of, or the imposition of probationary conditions upon, a certificate to practice podiatric medicine for any of the causes set forth in Article 12 (commencing with section 2220) in accordance with section 2222."

2. Business and Professions Code section 2234(b) provides that "In addition to other provisions of this article, unprofessional conduct includes, but is not limited to . . . (b) Gross Negligence".

3. Business and Professions Code section 2234(d) provides that: "In addition to other provisions of this article, unprofessional conduct includes, but is not limited to . . . (d) Incompetence."

of internal fixation, but gave the patient an unna boot and utilized tape.

The post-operation X-rays of October 16, 1984 demonstrate that the osteotomy sites failed to show good apposition. The left first metatarsal is markedly displaced plantarly, approximately 30 degrees. The right first metatarsal is slightly more displaced. Gaping is visualized dorsally. The right hallux is in extreme varus position. A lateral view of the right foot reveals an extreme plantarflexion deformity of the first metatarsal segment with very little bony apposition present. The October 22, 1984 X-rays reveal continual malposition, with significant shortening of first and fifth rays. The osteotomies both subluxed post-operatively and respondent obtained a second opinion which recommended internal fixation of both of the osteotomies.

Respondent was grossly negligent and incompetent in the performance of the osteotomy surgery and in the post-operative management of this patient as is more specifically set forth below:

SURGERY

1. Respondent was grossly negligent by failing to perform a complete initial podiatric physical and vascular examination prior to surgery. Respondent did not document a review of the dorsalis pedis nor posterior tibial pulses.

2. Respondent was grossly negligent in the selection of the diaphyseal location of the osteotomy site for both the first and fifth metatarsals. This location is improper due to

the greater incidence of nonunion. If performed in this region internal fixation should have been used. A bone plate or crossed pin should have been used in the shaft. Respondent was grossly negligent and incompetent in not recognizing the initial malposition and potential for nonunion.

3. Respondent was grossly negligent and incompetent in failing to recognize the malalignment of the osteotomy sites as revealed on the October 1984 X-rays. Respondent should have recognized the malalignment and rectified it early to effect prompt healing.

POST-OPERATION MANAGEMENT

Following surgery patient Julia B. experienced a shortening, delayed healing and malunion of the bones involved. The left foot was reoperated on with pins and wires placed in the affected bones.

Respondent was grossly negligent and incompetent in the post-operative management of patient Julia B. Respondent failed to recognized the mal-position and subsequent nonunion. The right fifth metatarsal was not properly fixated. A monofilament wire was used. Either a bone plate or crossed pins should have been used. Respondent failed to recognize malalignment of the osteotomy sites as revealed in the X-rays. Respondent should have recognized this and taken steps to effect prompt healing. Respondent subjected this patient to a second surgery for unrecognized malunion and failed to recognize a second malposition of bone after this surgery. This subjected the

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patient to a non-healing osteotomy for which further tertiary surgery was necessary.

B. Patient: Margaret M., Age: 75

This patient presented on June 3, 1985 with a complaint of "bunion and hammertoe each foot". On June 13, 1985 respondent performed a modified Lapidus bunionectomy bilateral and Akin osteotomy of the proximal phalanx of the hallux bilateral with lateral capsulotomy of the first metatarsal phalangeal joint, hammertoe correction by arthroplasty of the second digits bilateral and left fifth digit. No manner of fixation was used. Postoperative X-rays of that day show hallux varus, an improper post operative alignment. Post-operative shoes only were dispensed.

On June 15, 1985 follow-up visit, redressing with unna boot applied to both feet.

On June 18, 1985 soft dressing applied.

On June 21, 1985 another redressing.

On June 26, 1985 patient went without shoes for two days. Dorsal displacement of the first metatarsal on both feet is noticed.

On July 1, 1985 physical therapy and re-taping.

On July 8, 1985 physical therapy and re-bandaging.

On July 17, 1985 "left fifth digit was hit and swelled".

On July 22, 1985 X-rays show pronounced dorsiflexion deformity of the distal aspect of the first metatarsal.

On July 24, 1985 X-rays taken which showed metatarsal head "dropped down quite a bit, but in the process it has

dropped down quite a bit more". The July 24, 1985 pre-op diagnosis is "Non-union fracture at the base of the right first metatarsal, limitation of motion of the first metatarsophalangeal joint, right foot and flail left fifth digit".

On July 24, 1985 the following surgery was performed: "Repair of 'non-union' fracture, right first metatarsal at the base and a modified Keller bunionectomy of the right first metatarsophalangeal joint, syndactyly of the fourth and fifth digits of the left foot". Fixation effected with a stainless steel suture. Patient was fitted with non-weight bearing fiberglass cast.

On September 18, 1985 X-rays were taken of both feet. A lateral view of the right foot indicates a dorsiflexion deformity of the distal aspect of the first metatarsal and an oblique view reveals there is poor apposition of the osteotomized fragments with a gaping area centrally.

On September 24, 1985 surgery performed by Richard Ehlert, D.P.M. as follows: "Transverse dorsal capsulotomies of the 2nd and 3rd metatarsophalangeal joints with tenotomies of the extensor digitorum longus and extensor digitorum brevis of the 2nd and 3rd digits of the right foot as well as transverse osteotomies of the fifth metatarsal proximal to the surgical neck of the fifth metatarsal, bilateral". Follow-up visits in September of 1985 reveal the patient had increasing pain symptoms and difficulty getting to respondent's office. Patient is subsequently referred to Dr. Bell in Walnut Creek.

Respondent has engaged in unprofessional conduct in the care for this patient as follows:

1. Respondent was grossly negligent to perform an osteotomy of the first metatarsal on both feet with osteotomy of the hallux and bunionectomy as well as hammertoe procedures while providing the patient with only soft taped dressing and post operative shoes. No internal fixation was used. When the closing wedge osteotomies are performed in the proximal diaphyseal region of the first metatarsal some form of fixation or casting is required.

2. Respondent failed to recognize an immediate subluxation post-operatively of the osteotomy, specifically at the base of the first metatarsal. Incompetence is demonstrated when 6 weeks following the initial surgery, a diagnosis of nonunion is made of the right first metatarsal and staples were used. This is inappropriate for a displaced, through and through bone cut. This allows continued displacement and movement of the bone contributing to nonunion.

3. Respondent was incompetent for not providing immobilization.

4. Respondent's failure to recognize and treat a dislocation of an osteotomy immediately post-surgery evidences gross negligence. The osteotomy was not closed by the time of the second surgery on July 24, 1985. Respondent's failure to close the osteotomy with fixation constitutes gross negligence.

5. Respondents failure to diagnose the nonunion of the first metatarsal on the right foot constitutes gross negligence.

This nonunion continued to displace and the movement of the bone contributed to the nonunion.

6. Because of improper immobilization this patient suffered an additional mal-position and ultimate mal-union of the fifth metatarsal osteotomies. Post-operative X-rays of February 23, 1985 reveal a complete failure to reposition the fifth metatarsal osteotomy site. There is almost no bony apposition between the fragments and a useless metallic fixation device is observed in the operative site. There was no reduction of the marked displacement prior to the fixation. This constitutes gross negligence and incompetence.

7. In his treatment of this patient respondent has repeatedly failed to recognize significant post-surgical complications. Respondent has failed to effectively correct post surgical complications, encouraged and allowed a colleague to perform additional unwarranted and unwise surgery not related to the ongoing problem on this patient in spite of the ongoing complications from the initial surgery. Respondent's failure in the first immobilization of the first metatarsal osteotomy was followed by his second failure to improperly immobilize the mal-union of the fifth metatarsal osteotomy. This conduct constitutes gross negligence and incompetence in the care of this patient.

8. On June 13, 1985 respondent used 20cc of marcaine 1/2% with epinephrine as a total ankle block. Respondent utilized epinephrine with the local anesthetics for digital blocks. This is contraindicated in the digits due to potential

circulatory embarrassment in this 75 year old patient who had a history of hypertension. This constitutes gross negligence.

C. Patient: Annette J., Age: 26

This patient presented on April 20, 1983 with a chief complaint of painful bunions bilaterally and fifth metatarsal heads laterally.

On April 22, 1983 the following procedures were performed on the patient's left foot: "Displacement osteotomy left first metatarsal at surgical one-third distal metatarsal. Silver bunionectomy left foot. Osteotomy left fifth metatarsal bone."

On April 29, 1983 the identical procedures were performed on the right foot.

On May 9, 1983 a second metatarsal osteotomies were performed using minimal incision techniques. The postoperative X-rays demonstrate the 2nd osteotomies to be in the diaphysis, approximately in the junction of the distal and middle one-third of the bone.

On June 26, 1984, the patient is seen by Dr. Kruger. The majority of the patient's complaints relate to the third and fourth metatarsal heads. The patient is referred to the California College of Podiatric Medicine. The patient has excessive elevation at the previously performed osteotomy sites. The patient will develop hallux limitus. An osteotomy of the third and fourth metatarsals is recommended. This is eventually performed by Dr. Kruger on October 14, 1984.

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Respondent was grossly negligent and incompetent in the performance of the osteotomy surgeries and in the post-operative management of this patient as is more specifically set forth below:

SURGERY

1. Respondent was incompetent by failing to perform a complete initial podiatric physical and neurological evaluation. Respondent only notes that Babinski reflexes are absent.

2. Respondent was incompetent in performing extensive bone surgery two days following the patient's initial presentation. No alternative treatments are tried or explained. The patient was not given an ample amount of time to consider other treatment options. Respondent failed to pursue conservative therapy which he attempted on the first visit and orthotic treatment which he instituted preoperatively. The continuance of conservative care may have alleviated the necessity for subsequent surgery.

3. Respondent was grossly negligent and incompetent in the selection of the diaphyseal location of the osteotomy site for both the first and fifth metatarsal surgeries. Respondent cut through the bone at the distal-most aspect of the metatarsal in the region of the neck. This location is improper due to the greater incidence of nonunion. If performed in this region internal fixation should be used. Diaphyseal osteotomies have a tendency to shorten due to more bone resorption at the osteotomy site unless extensive fixation is utilized. The X-rays substantiate the elevation of the capital fragment and

significant shortening of the first metatarsal. This causes excessive compensatory stress to the lateral segments of the foot.

4. Respondent was incompetent on May 9, 1983 by performing osteotomies of the second metatarsals ten days following osteotomy of the first and fifth metatarsal (April 22, 1983). The other osteotomy sites are not particularly stable at this point in time.

D. Patient: Wanda K.

This patient presented on August 22, 1984 with a complaint of a painful ingrown right hallux nail that had been symptomatic for a few months.

On May 30, 1985 a "modified lapidus bunionectomy and Akin osteotomy at the proximal phalanx is performed bilaterally. A base wedge osteotomy of both first metatarsals was performed, the right foot osteotomy in the diphyseal portion of the bone, the left osteotomy being a through and through cut. Akin type osteotomies were also performed bilaterally. The left close to the joint line and the right at the junction of the metaphysis and diaphysis. No form of fixation is demonstrated. Postoperative medications includes Naprosyn and Augmentin.

On June 3, 1985 a culture is taken because of "seepage from the wound." A June 6, 1985 culture revealed a heavy growth of gram positive rods. On June 7, 1985 Augmentin is again prescribed.

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On June 10, 1985 bilateral second metatarsal osteotomies were performed. On June 12, 1985 Augmentin is discontinued and Bactrim is prescribed.

On June 26, 1985 the patient discontinued Naprosyn upon orders from her family doctor due to possible allergic reaction.

On September 3, 1985 surgery is performed as follows: Osteotomy third metatarsals, exostectomy of fourth toes, soft tissue release for recurrent hallux valgus left, and ingrown surgery left hallux. Naprosyn was again prescribed postoperatively.

Respondent was grossly negligent and incompetent in the performance of the osteotomy surgeries and in the postoperative management of this patient as is more specifically set forth below:

SURGERY

1. Respondent was incompetent on June 10, 1985 where he performed a second metatarsal osteotomies bilaterally eleven days following the bunion surgery of May 30, 1985. There is no acceptable medical necessity for this procedure at that time.

2. Respondent was grossly negligent when on May 30, 1985 he performed a right first metatarsal osteotomy in the diaphyseal location. Respondent did not utilize some form of rigid bone fixation such as a pin, wire, screw, or bone plate.

The left foot osteotomy site of the first metatarsal was not stabilized by a rigid form of fixation. No portion of cortex of bone is intact.

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3. Respondent was incompetent when six days following surgery he prescribed Augmentin. A culture was taken on June 3, 1985 because of wound drainage. On June 7, 1985 Augmentin was again prescribed. The antibiotic sensitivity patterns do not support this prescription.

4. Respondent was grossly negligent when he performed bilateral osteotomies of the second metatarsals three days after antibiotics were prescribed for a suspected infection at the initial operative sites. Respondent should have reassessed the infection and eradicated the suspected infection and recultured prior to an additional surgery. It was inappropriate to perform this elective procedure while there were lab indications of infection.

5. Respondent was incompetent when Naprosyn was prescribed post-surgery on September 3, 1985. The patient was potentially allergic to this medication (June 26, 1985 note).

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Wherefore complainant prays that a hearing be held pursuant to the Administrative Procedure Act (Government Code section 11500 et seq.), and that following such hearing the Board of Podiatric Medicine revoke or suspend the license of respondent or issue such other order as warranted by the evidence, and that complainant be compensated by respondent for the costs of investigation and prosecution of this case pursuant to Business and Professions Code section 2497.5.[4]

DATED September 6, 1988

CAROL SIGMANN
Executive Officer
Board of Podiatric Medicine
BOARD OF MEDICAL QUALITY ASSURANCE

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4. Business and Professions Code section 2497.5(a) provides: "The board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case."